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Piachaud, Jack

Postprint / Postprint

Zeitschriftenartikel / journal article

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Empfohlene Zitierung / Suggested Citation:

Piachaud, J. (2008). Globalization, Conflict and Mental Health. *Global Social Policy*, 8(3), 315-334. <https://doi.org/10.1177/1468018108095631>

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Globalization, Conflict and Mental Health

JACK PIACHAUD

Medical Foundation for the Care of Victims of Torture / Medact, UK

ABSTRACT Violent conflict for political ends, including war and civil war, is a major cause of mental ill health and although there are different approaches and ways to understand this relationship some consensus is emerging on the psychological, social and cross sector responses to post conflict situations. Globalization has changed the relationships of nation states, corporations and international organizations creating different patterns of political violence and different ways to organize the responses. Victims, weapons and humanitarian aid are considered within a public mental health framework, describing the consequences of war and other forms of political violence. Secondary and primary levels of intervention in public mental health consider the monitoring, preparation for and prevention of political violence, taking the new sciences of human relationships as a basis to look at international relationships. The need to re-establish a reformed United Nations at the centre of global decision making and to increase the global expenditure on peace making are two conclusions from this analysis.

KEYWORDS *globalization, mental health, political violence, psychological trauma, war*

Introduction

This article comes from a mental health perspective, in that it is aimed at the prevention and amelioration of mental ill health and the promotion of mental well-being. As a starting point violent conflict is seen as a major cause of mental ill health (Murthy and Lakshminarayana, 2006); the Cairo declaration

of the World Psychiatric Association in 2002 (Okasha, 2006) asserts that mass violence is a major public health problem with important mental health implications, urging research and training on both its consequences and its prevention. Taking a public health approach to conflict (Levy and Sidel, 1997) allows examination of broad determinants and consequences, of impacts on populations, while addressing practical and policy issues in a variety of scenarios.

The three elements of globalization, conflict and mental health, are huge in their ramifications and the article will start by outlining some key aspects of each, also considering how they might interact with each other. This is followed by a more detailed analysis of mental health and conflict within a public health framework.

GLOBALIZATION

Globalisation itself is neither good nor bad. It has the power to do enormous good. But in much of the world it has not brought comparable benefits. For many, it seems an unmitigated disaster ... (Stiglitz, 2002: 20)

The propensity for humans to trade and travel, to impose their views, to capture the resources at a global level is not new; it has been part of their activity as far back as we can tell, with different epochs having different areas in dominance (Toynbee, 1976: 27–37). There is debate as to whether the current global relationships are simply part of a continuum (Hirst and Thompson, 2002) or whether there has been a step change, a technological revolution equivalent to the agrarian or industrial revolution, which takes us into a new and exciting domain (Friedman, 1999), or if ‘... a much less governable world is the inevitable result of the forces ...’ (Gray, 1998: 67).

Major changes in sovereignty and the place of the nation state are part of globalization; activities within a state no longer being the sole province of government. The changes in information technology and media have allowed information that was previously hidden to become more open, the transnational corporations have removed financial control from many nations and the international organizations such as the United Nations (UN), International Monetary Fund (IMF), World Bank and the World Trade Organization (WTO) have established an international superstructure that some see as an emerging global governance while others see as simply adding complexity to the Hobbesian jungle of human social relationships (Weiss, 2000).

Globalization acts on health through institutions, economics, cultural and societal changes, migration and environmental change, from global policy to the individual (Huynen et al., 2005), and with a profound negative impact for many on unequal access to the determinants of good health (Koivusalo, 2006). Privatization of health care adds to this burden; a similar picture is emerging for mental health (Kelly, 2003; Okasha, 2005).

CONFLICT

Violent conflict has played a central role in the emergence of globalization, the 'Long War' described by Phillip Bobbit (2002: 24) defining the final acts of the nation states from 1914 to 1990 before giving way to what he describes as the 'Market State'. The new technologies and social processes of globalization influenced the winning of this war while the conflict itself helped forge these; in this view conflict and globalization are inextricably entwined.

Following the collapse of the Soviet Union there was a period of optimism that a new world order less rooted in violence would emerge and the idea of a liberal peace gained some credence (Duffield, 2001: 11). There is evidence that the number of wars, battlefield deaths and genocides actually decreased during the 1990s (Human Security Centre, 2006); however, a series of civil conflicts typified by Chechnya, Rwanda and Yugoslavia, suggested a new set of conditions for war had emerged following the loss of the old, containing, political structures. In addition, a more fundamental shift in world order, submitting the poorer nations to networks of corporate and transnational interests, appeared to be behind some conflicts, particularly those in sub-Saharan Africa involving diamonds, coltan and other natural resources (Kaldor, 1999). Asymmetrical conflicts have emerged, some with little use of new technologies, but which are population based, diffuse and hard to monitor, using terror, especially suicide bombings as an instrument of violence. A particular asymmetrical conflict emerging over the Middle Eastern oilfields uses highly organized networks and new globalizing technologies with the ability to reach into population centres such as the case with 9/11 (Abbot et al., 2006).

The state, religion and corporate interest appear to be key institutions of war. Some point to a clash of civilizations, describing an ancient human process of group formation and identity driving us to conflict (Huntington, 1997), while others see the roots of violence in the desire for wealth and power, with religion and nationalism being used to engage popular support, and an increased merging of crime, war and private profit (Kaldor, 2004). Definitely new are the size, speed and complexity of the networks that are determining the liberal peace, the new wars, and the moral choices before us (Duffield, 2001).

From a health perspective the term political violence draws attention to the complexity of the causes and the consequences of violence and the systemic impact on health (Zwi and Ugalde, 1989). Violence used for political purposes such as war, civil war, genocide, violent repression of populations and torture, merges with structural violence, the suffering brought about through social structures maintained by political power (Farmer, 2003: 8), such as poverty and the lack of health care. Identifying the political processes allows preventative strategies and advocacy to emerge (Patel et al., 2006) while in terms of risk, political violence carries with it the greatest threat to human well-being, ultimately the destruction of our civilization and perhaps humanity itself through war and weapons of mass destruction.

MENTAL HEALTH

There are different models of mental health and illness; unlike the body, the mind is not the province of medicine, and while there have been great gains by applying biomedical models and classifications such as ICD10 to abnormal thoughts and behaviours (WHO, 1992), the mind still remains firmly attached to society (Geertz, 2000: 203–17). This period of globalization has seen western ideas, especially the biomedical approach and its focus on individual pathology, dominate the global discourse (Bracken and Thomas, 2005: 28–30), largely ignoring views from other cultures and the still strong link between spiritual matters and the mind. Some argue that because mental well-being is so embedded in culture there must be a greater exchange on these matters (Skultans and Cox, 2000). The biopsychosocial model emerged within psychiatry (Engel, 1977), in an attempt to broaden the theoretical base of psychiatry, but the psychological and social theories have largely been picked up and developed by other disciplines (Pilgrim, 2002) and any consideration of mental health requires a multi-disciplinary approach.

Globally, the burden of mental health disorders is associated with poverty, human rights abuses and stigma, and the needs of those with severe mental illness are often neglected (WHO, 2003). Severe mental illness is often considered to be more biologically determined and there appears to be a psychosocial space, wherein happiness and well-being exist with depression, anxiety and sadness, frequently referred to as common mental disorders; there is considerable evidence of social causation for these (Brown and Harris, 1978; Patel and Kleinman, 2003). This has particular relevance for conflict, where the external social impact is so dominant, though even with conflict related disorders individual attributes influence outcome.

There have been significant disagreements between mental health professionals in understanding the impact of traumatic events and how to respond to them; the term Post-Traumatic Stress Disorder (PTSD) has been criticized and the motives of a growing 'trauma business' have been questioned (Summerfield, 2002). However, a greater consensus may be emerging (Van Ommeren et al., 2005: 73), the authors concluding that 'there is considerable agreement on what constitutes good public mental health practice'. Psychosocial interventions after conflict aim to promote community cohesion, disrupted by war, and support those most affected and in the longer term consider peace building and justice through locally appropriate means (Inter-Agency Standing Committee [IASC], 2007) as traditional models of healing may promote a society's sense of worth and ability to recover from traumatic experiences (Gidley and Roberts, 2003).

There are concerns that the impact of war may increase the likelihood of future violence through hatreds and the desires for revenge and through the disruption of normal attachment processes in child development leading in turn to cycles of violence (De Zulueta, 2006). War itself has been considered a form of social mental pathology (Poteliakhoff, 2006: 3). This, however,

extends the meaning of mental disorder beyond the usually accepted notions and there is also a view that war has been a normal part of nation building and law making (Howard, 2002: xvi).

Public Mental Health and Political Violence

Public mental health is more than evaluating interventions, population surveys or public education; it must examine the broad determinants of mental health such as poverty, social isolation, social upheaval and violence, work on prevention of mental disorder at local, national and global levels and consider how to maximize mental health.

The application of public health models to political violence also focuses analysis and intervention at so called 'primary, secondary and tertiary levels' (Levy and Sidel, 1997: 389), where the causative process, in this case political violence, is absent at a primary level, emerging at a secondary and giving rise to morbidity and mortality at a tertiary level. In this public mental health model the tertiary focus is on the impact of violence on mental health, the treatment of disorders, the management of the psychological and social issues, and rehabilitation. At a secondary level there is a need to consider how actual violence emerges from a background of sub-violent political conflict. At a primary level the focus is on understanding the root causes of violence and political violence.

TERTIARY LEVEL

Globalization influences the mental health consequences of conflict through the models and language used by western psychiatry and whatever the debates, new information has come from these scientific and epidemiological approaches. Globalization has also influenced who the victims of violence are and the impact on those victims, especially soldiers and displaced civilian populations. New weapons have emerged through new technologies while new forms of communication and social organization have led to new responses. These matters are part of the tertiary level consideration.

EPIDEMIOLOGY

There have been several epidemiological studies using standard criteria for mental disorders such as PTSD, anxiety and depression, summarized by Murthy and Lakshminarayana (2006), which give a measure of the morbidity caused by political violence. Risk factors include gender (women being more at risk), exposure to traumatic events, lack of social support, migration and subsequent life events. The morbidity is great with prevalence rates for PTSD and common mental disorders reported as high as 70% or 80% in a sample of refugees and those caught acutely in war. The WHO (2001) estimates that 10% of people who experience severe traumatic events will develop serious

mental health problems and another 10% will develop behaviours that will hinder their ability to function effectively.

There have been descriptive studies looking at longer term social reconstruction and functioning (Gutlove and Thompson, 2004), there is data on long term sequelae of psychological suffering (Bramsen and Van der Ploeg, 1999), on the relationship to family breakdown and violence (Orcutt et al., 2003), on trans generational impacts (Yehuda et al., 1998) and on the desire for revenge (Cardozo et al., 2003). Alongside this is a concern about an over-medicalization of PTSD and a need to focus on issues of resilience and the variance in response to treatments (Stein et al., 2007).

Victims of War

Increasing globalization has come hand in hand with increasing global violence. Deaths through war in the 20th century are estimated at around 190m; estimates of military deaths per million rising from 10m in the 19th century to 180m in the 20th century and civilian deaths rising from around 10% of all deaths at the beginning of the century to 60% or more at the end (Garfield and Neugut, 1997; Meddings, 2001). The injuries of war are estimated as ranging from 0 to 13 per death, for different weapons and scenarios (Coupland and Meddings, 1999); there is no such ratio established for mental health disorders yet for each death there must be an associated mental impact on observers, relatives and perpetrators; and for each injury a victim and risks of disability.

SOLDIERS

The recognition by the military of the mental effects of war has added to our understanding of cause, consequence and treatment of violence related mental health disorders (Jones and Wessely, 2005). The difference between the mental health impact of the Iraq War compared to the Gulf War (Horn et al., 2006) supports the suggestion that medical countermeasures in 1991 were associated with ill health and that different arrangements for war preparation, health care and surveillance in the Iraq War may have led to a reduced incidence of mental disorders.

Differences are emerging in psychological sequelae between US and UK troops serving in the Iraq War, with UK troops showing no greater evidence of PTSD or depression than those deployed elsewhere (Hotopf and Wessely, 2006), while up to 20% of the US troops show symptoms of PTSD and 25% receive mental health diagnoses on return (Seal et al., 2007). Selection, training, experience and deployment have been suggested as reasons for this difference but it is clearly sensitive and remains unexplained. It is, however, remarkable that a group of young people can be deployed in war, suffer serious physical casualties, take part in all the horrors of war and yet apparently suffer no psychological consequences. This may support the view that mental

health problems following violent conflict are largely determined by social relationships and this clearly needs long-term follow up.

Rapid emergency treatment on the battlefield, improved body armour and rapid extraction to high-tech medical facilities outside the battle area appear to be associated with an increasing number of chronically disabled servicemen in the USA through increased survival. Traumatic Brain Injury from explosions is the major cause of neurological damage with severe long-term psychosocial consequences (Nerve Centre, 2006). Young men in military or in militia service remain the major direct victims of war in terms of mortality and morbidity (Human Security Centre, 2006); how those who do not have access to modern medicine are faring in Iraq or Afghanistan is largely unknown.

DISPLACED PEOPLE

The movement of people fleeing from war is not a new process; the vast majority still journey to the nearest place of safety, either internally displaced or in neighbouring countries (UNHCR, 2006a). In addition to the more acute problems of movement, there are 38 long-lasting and intractable situations accounting for some 6.2m people, most in Africa but the best known probably being the Palestinians in the Middle East. Long-term refugee camps present with many mental health problems, skewed populations, chronic lack of opportunities for children, general ill health and may help maintain the conflicts from which they arose, as sources of combatants and grievance (Kett, 2005).

For the richer world the globalizing aspect of this problem is asylum seeking. The number of people seeking asylum in Europe has varied depending on conflicts, changes in trafficking and European asylum processes, from around 100,000 in 1983, peaking in 1992 at around 700,000 and in 2002 at around 500,000 but falling to just over 200,000 in 2006 (UNHCR, 2006b). A recent report from the UK Parliamentary Joint Committee on Human Rights (2007) noted that, while there is anxiety about immigration causing rapid changes in our communities and increasingly punitive approaches to asylum seekers, the majority of people in our society are financially better off and benefiting from the processes of globalization, reflecting the Stiglitz (2002) view that some wish to reap the benefits while letting others pay the price.

The mental health problems of asylum seekers in the UK are considerable and management is complex (Tribe, 2002). This globalizing problem of forced migration has resulted in the UK in a very mixed group of people, with different cultures, expectations, personal experiences, innate capacities, unknown early experiences, dislocated from their social roots, presenting to services with misery attached to past experience, dreadful transit and present uncertainty. Although relatively small in number the services are still struggling to cope with this group appropriately (Ward and Palmer, 2005). The Joint Committee (2007) warned that the process in the UK in many cases lead to a failure to protect asylum seekers from inhuman and degrading treatment.

Weapons

The new technologies have brought about new weapons while new markets have brought about increased distribution of older weapons. Most mental health research concentrates on the relationship between victim, the events experienced and the social circumstances but not on the weapon used. Is the unseen enemy in the sky more likely to cause psychological disturbance than the enemy at the gates? The notion of shock and awe in Iraq may have had similarities to the practice of the Blitzkrieg, but the latter was defined in military not psychological terms.

The use of psychological jargon has come into military language. Psychological Operations, or 'PsyOps' have been reported in recent conflicts (CNN, 1999) using all available media – leaflets from the air, radio, TV and Internet – to foment unrest against leaders and create fear. Such propaganda is intended to undermine psychological strength, but how it relates to the ultimate psychological sequelae of a war is unknown. The International Committee of the Red Cross in a project to outlaw weapons causing 'Superfluous Injury or Unnecessary Suffering' included a category of abnormal psychological states (Coupland, 1997). Psycho active substances are probably part of chemical weapons development (Wheelis, 2002) but their potential impact is as yet unknown.

There is some evidence that chemical weapons have a special psychological effect; survivors of chemical attacks in the Iran–Iraq war show particularly high levels of PTSD some years after the events (Hashemian et al., 2006), perhaps related to the unseen nature of the attack, the fear and rumours that are associated with such a weapon and the fear of dying of asphyxiation. A similar effect might hold true of biological weapons; after the anthrax attacks in the USA there were reports of high stress levels and avoidance of public systems (Gray and Ropeik, 2002). The mental health sequelae of the atomic bombs at the end of the Second World War were profound, unexpected and documented in Robert Lifton's (1967) account, *Life after Death*; the impact is still measurable today.

Some might argue that the suicide bombing is a new weapons system. The relationship of suicide bombing to mental health is complex, but it is more likely to arise as an instrumental aspect of war from asymmetrical conflict than from psychopathology (Grimland et al., 2006). Experience in Israel suggests the mental health consequences are considerable, both to direct victims and the wider community with suggestions that susceptibility and resilience are factors that change over time, reflecting both internal, personal and external social factors (Bleich et al., 2006). An increasing fear is that highly destructive weapons can be created and distributed into population systems by the new global terrorist networks using suicide agents, this fear becoming one of the drivers for the wars in Iraq and Afghanistan (Rogers, 2006: 2).

Hand guns, small arms and light weapons are more available due to the freer global markets and looser national boundaries with a global trade worth

about US\$10bn. Most illegal small arms start in the legal market but the regulation required to monitor and control the flow is lacking (Arya, 2002). One third of the world's 700m firearms are to be found in the USA, and move from there to all parts of the world. The burden in death in the year 2000 was over 400,000 people (Cukier and Sidel, 2006: 14), with great regional variations, the majority that year being due to suicide. The psychosocial impact of small arms has been estimated in a variety of settings (Mahmudi-Azer, 2006) but detailed epidemiological work on mental health and gun use is not available. Traditional codes of conduct containing violent conflict become overwhelmed when guns replace knives and spears, leading to a spiralling violence and death, hastening the break up of traditional cultures with grave psychosocial consequences (Gebrewold, 2002). As Meddings (2001) observes 'concentrated 20th Century killing power resting in the hands of individuals with fifteenth century organisation and discipline', the parallels with gangs and urban crime are evident.

Humanitarian Response

As the International Committee of the Red Cross commenced its humanitarian mission in the 1860s, the First Geneva conventions were established to allow for the treatment of soldiers in war; these conventions were later extended to the protection of prisoners of war and to civilians caught up in war and civil war. Such sentiments to help and protect people from war were not new to humanity (Meddings, 2001) but these two events prepared for the oncoming globalization of war.

Key players in this area are the big non-governmental organizations (NGOs), such as Médecins Sans Frontières, Médecins du Monde, the Red Cross and Crescent, the International Medical Core, Action Aid, Oxfam, along with international governmental organizations (IGOs), such as the WHO, UNICEF, UNHCR, Office for the Coordination of Humanitarian Affairs (OCHA); however, it is essential not to ignore the small NGOs, many faith based, that may be local or global in their reach and more difficult to bring into a coordinated action. Three themes are briefly explored here: the relationship of the military to the humanitarian effort, post-conflict health and mental health.

In the last few decades the networks and relationships between humanitarian and military actors has become more complex and intense. Increasingly Peace Support Operations (Court, 2004; Pugh, 1998) are leading to active military involvement in the post-conflict humanitarian work with civilian populations. The UN role of peace making and peace keeping, the need for security to allow humanitarian activity to take place and the political notion of winning the hearts and minds appear to be part of this development. With the diminution of the UN role in the last decade, these activities have become incorporated into national armies, especially the US and UK military.

Where there is conflict it is clear that there must be a relationship between those who provide security and those who provide aid; however, this military role in providing humanitarian assistance has been criticized, seen as risking confusion between humanitarian workers and military, thus placing humanitarian workers at risk (Bristol, 2006). There are more deep-seated concerns with suggestions that the fundamental principles of impartiality, neutrality and independence require a clear distinction between the two activities (Struder, 2001).

Three recent wars have seen very different processes of post conflict health reconstruction. In Kosovo, there was no local ministry of health and the WHO took on a primary planning and implementing role with services coming from a mixed set of providers (Shuey et al., 2003). In Afghanistan there was an early and significant role for NGOs, the World Bank and other donors supporting the Ministry of Public Health in coordinating activities (Cook, 2003; Palmer et al., 2006). A third model developed in Iraq, with extensive use of the private sector, both in terms of planning and in delivery (Medact, 2006). Each of these situations is very different in terms of security, the nature of the conflict and the structure of health care.

The criticisms of the first two models have been that the WHO dominance leads to too much central planning and insufficient enablement of local actors, while the NGO model is too fragmented and allows certain interest groups too much local power. These are natural tensions; the key problem is how to bring in the local skills and enable local actions while maintaining coordination and distribution of resources based on population needs assessments.

As in the development field there have been concerns expressed over the increasing role of the private sector in post conflict health provision, which has been the dominant model in Iraq. A significant criticism of this model is that those agencies with experience in post conflict were not engaged in the reconstruction and there was a serious lack of coordination with a failure to develop an early health response (Medact, 2006).

The issue of rights and equity would seem to demand a service based on population need. This seems of particular importance in the mental health arena. A comprehensive package for considering and delivering mental health and psychosocial support in emergencies, including war, is well described in the IASC guidelines (IASC, 2007) with six guiding principles: responses should be built on human rights and equity; on participation of the affected population; that any intervention should not cause harm to any group; that interventions should build on available resources and capacities; there should be integration of activities across providers and all sectors; and intervention needs to be multi-layered, with different types of activity and response to different groups and severity of problems. Although at pains to emphasize empowerment and local involvement, there will be a risk that it becomes translated into a blueprint for action, with programmes being delivered through rigid vertical processes. Evaluation will be complex and funding for mental health remains a low priority.

The management of pre-existing severe mental illness remains a key factor post-conflict as these people are among the most vulnerable. There is little data on how they manage during war. There is a risk that the focus on 'post-conflict mental health', on 'trauma' and on the 'psychosocial' might detract from services for those with long-standing and enduring mental illness.

Secondary Levels

At the secondary level the causative process, political violence, has started but has yet to break out into open hostilities or overtly damage mental well-being. Most human societies exist in this state with political violence around them in time and space and preparation for political violence within; we live in a state of 'para-war', being constantly beside and reminded of war. Our streets hold memorials to war, our history is punctuated with war, and our media bring daily news of war; yet we know the mental, social and physical effects of war are horrific.

The tasks at this level of intervention include assessing the impact of the threat of violence, preparation for conflict, monitoring the likelihood of violent conflict breaking out and considering interventions that might reduce the likelihood of violence. Though these move well beyond the spheres of mental health and health in general, health policy and professions have roles in these activities, which are global in their scope.

The mental health impact of the threat of violence is hard to estimate; however some observations from areas of conflict such as Northern Ireland suggest that perception of the risk of violence is an important factor in mental well-being and that denial of risk is an important protective device (Cairns and Wilson, 1984). There is evidence that the fear of nuclear annihilation is associated with anxiety, though not necessarily causative (Poikolainen et al., 2004). Whether to develop programmes on these issues must depend on the prevalence of these ideas and the likelihood of the feared concern.

Protection from mental health sequelae of violence has been carefully considered within the military and the NGO humanitarian agencies. The low incidence of PTSD in soldiers serving in Iraq has been in part attributed to pre-conflict training (Hotopf and Wessely, 2006). Many NGOs working in humanitarian crises consider training, supervision and self care as important devices to protect the mental welfare of their staff (IASC, 2007). For helping general populations cope with the threat and presence of violence, evidence comes from areas of chronic war, such as the Middle East and South East Asia, such as observations that training of school children in war situations can reduce the risks of mental health consequences (Minowski, 2000). Resilience, the individual capacity to manage traumatic events, requires greater understanding and emphasis.

The preparation for war influences the likelihood of war in a complex manner, as some aspects may deter an enemy but others may endorse the idea of

war. In monitoring the likelihood of war, indicators include preparations for war and observations of language used in the media, such as the radio in the Rwandan genocide. Health professionals may monitor the incidence of violent deaths and injuries in particular areas of strife such as in the Horn of Africa (Gebrewold, 2002); mental health professionals have played a role in monitoring the use of torture in various countries through assessments of asylum seekers (Medical Foundation, 2002). This health data, collected from many sources and used with political and social data may help draw the attention of the international community to particular emergent problems, with the new globalizing communication networks sharing information and strengthening advocacy.

Interventions that reduce the likelihood of violence intensifying have become a global priority, encompassing action in many spheres, governmental, intergovernmental, UN and NGO (Department for International Development, 2006), with increasing realization that conflict is hindering the achievement of the Millennium Development Goals in many areas, while the failure of development increases the likelihood of violence. The boundaries between development aid and pre and post conflict humanitarian support are blurred and overlapping, as are the distinctions between peace building and psychosocial programmes, where the essence is to promote social cohesion, dialogue and social capital. There are roles for health policy in this including such programmes as 'Peace through Health' and 'Health Bridges for Peace' (Arya, 2004), and some specifically mental health related tasks, examining the psychological and social processes in particular conflicts or situations (Alderdice, 2007).

Primary Levels

At a primary level the search is for a deeper understanding of human conflict about which mental health writers have much to say. The correspondence in 1932 in which Einstein asked Freud if there is a solution to war provoked two observations; first that humankind has an instinctual drive for destruction and second that this individual drive is contained by a communal authority that emerges from a power struggle within the community. Freud goes on to say: '... attempts are made by certain rulers to set themselves above the prohibitions which apply to everyone ... to go back from a dominion of law to a dominion of violence ... the oppressed members of the group make constant efforts to obtain more power ... they press forward from unequal justice to equal justice for all' (Freud, 1950: 277).

There are other explanations of the human capacity for violence highlighting positive drives of attachment, of respect and of relationships (De Zulueta, 2006; Fromm, 1997; Gilligan, 2000). Attachment theory proposes that the failure to provide the right emotional environment for infants and children risks increasing their capacity for hatred and dehumanizing; these being the

attributes necessary to be taken up in the crusade, the jihad or the jingoism. Bringing evidence to bear from many sources these authors suggest that the proper regard for all humans has become a matter for the science of survival, as well as morality. Strategies to reduce the likelihood of violence are essentially to ensure good economic and social fabric for people, especially those in conflict, those fleeing from conflict and those from the most deprived spheres of our communities.

The struggle identified by Freud between those in power and those underprivileged is quite apparent today as a driver for major conflict. The social determinants of health are very similar to the social determinants of violence, at the centre is the inequality of wealth, which influences the individual through childhood and into adulthood (Wilkinson, 2005). Feelings of shame are most associated with violent thought and actions (Gilligan, 2000). The drivers of war in the developing countries include extreme poverty, political, economic and social inequalities (Stewart, 2002), though wealth itself may bring conflict as in the notion of the 'resource curse' for such countries as the Democratic Republic of the Congo (Kett and Rowson, 2007). The analysis of Kaldor (1999) and Duffield (2001) cited earlier is that the economics of greed and fear are the prime movers of political violence in the wealthy world.

At this primary level of intervention the search is for the right way for human society to conduct itself to diminish the likelihood of political violence and maximize mental health and such policy for future action should take account of these emerging sciences of human relationships (Piachaud, 2006). When considering the global application of our understandings of human relationships, bearing in mind the future risks of climate change, the energy crisis and nuclear proliferation, the path that emerges for reduced likelihood of conflict is the need for greater equity and greater strength to global governance and to communal authority; the question at this primary level being whether these global challenges can be met without descending back into the global conflicts of the 20th century.

It is hard to see how this goal can be achieved without the institution of the United Nations being reformed and brought back to the centre of global decision making. In his book, *Collapse: Tracking the Failures of Human Societies to Deal with their Vital Environmental Risks*, Jared Diamond (2005) identifies factional governance, using power, roles and rituals to fight over dwindling resources as the least successful model, and yet this is how the current global governance might be construed. While some degree of argument and factionalism are inevitable, global agreements and treaties between nations on the use of the global resources must emerge and be compelling. For the globalizing corporations and financial institutions some greater democratic accountability must be developed and ways of ensuring they have social responsibility for the societies in which they operate, not simply wealth creation, built into their governance (Bennett, 2002). In terms of global law, the Report by the International Commission on Intervention and State

Sovereignty (ICISS, 2001) *The Responsibility to Protect* needs to come into much greater prominence when considering the use of deadly force to resolve political conflicts and the International Criminal Court needs to be ratified by all nations.

In considering the global militarism that emerged during the last century, treaties on disarmament need to be more rigorously followed and new treaties on small arms registration and monitoring need to be agreed. The global burden of military expenditure has passed the one trillion US dollar mark. In 2005, the UN budget for all its functions was at US\$12bn, 1.4% of the global military expenditure (Global Health Watch, 2006: 262), less than the US earned in arms sales in 2003 (Mahmudi-Azer, 2006). There must be greater global emphasis on peace making, understanding the issues that drive us to war and a far greater expenditure on research, evaluation and application of practice (Elworthy, 2004).

Conclusions

The relationship between conflict and mental health is increasingly well described. This article has reviewed some aspects that relate to globalization and has proposed a model of public mental health, which considers analysis and actions at various stages of conflict, and lends itself to the development of policy, both in health service delivery and at more political levels.

At a tertiary level the consequences of war are overt and in one respect it is '*plus ça change plus ça le même chose*' as suffering from bereavement, personal threat and disruption of family and society has been part of humanity since its beginnings and there are some commonalities across time and space that unite us. There are, however, differences that are bound to language, culture, the new nature of war and new global institutions. Our models of mental health will continue to evolve along with our culture and the language we use to describe them; new forms of warfare and new weapons will create the context within which these mental health problems emerge; social attitudes to forced migrations will evolve and influence the well-being of those caught up. There will be an ongoing need to research and assess these relationships, but we already know enough about promoting welfare to be critical of the global responses to refugees and victims of war and to advocate for greater resources and coordination of responses. The last 10 years has shown that market driven responses to post-conflict fail more comprehensively than globally coordinated responses focused on equity and population well-being.

At a secondary level there is recognition that war is ubiquitous and that societies exist in a state of 'para-war'. Important roles that promote mental well-being include understanding better how the threats of war impact on populations, preparation when the risks of facing open violence are high, monitoring the emergence of open violence and seeking interventions that

reduce the likelihood of violent conflict. The synergies between peace-building and psychosocial interventions need further exploration as does the emergence of global networks working on these issues.

At a primary level two key issues arise; one is the human propensity for violence with some clearer explanations emerging from the multidisciplinary fields of human relationships and the need for far greater expenditure, research and application on issues of peace making. The second is the need for stronger global governance and a strengthened role for a reformed UN, acknowledging that regional squabbles over resources by competing powers and trans-national organizations is the least likely path for sustainable peace.

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RÉSUMÉ

La Mondialisation, la Conflit, et la Santé Mentale

Les conflits violents pour atteindre des fins politiques, y compris la guerre et la guerre civile, la cause considérable de maladie mentale, et bien qu'il y a des façons différentes d'aborder et de comprendre cette relation, un certain consensus émerge sur les réponses psychologiques, sociales, et intersectorielles à la suite des hostilités. La mondialisation a changé les rapports parmi des États-nations, sociétés, et organismes internationaux, créant des modèles différents de violence politique et des façons différentes d'organiser des réponses. Cette article considère les victimes, les armes, et l'aide humanitaire dans un cadre public de santé mentale en décrivant les conséquences de la guerre et d'autres formes de violence politique. Les niveaux secondaires et primaires de l'intervention dans la santé mentale publique devraient tenir compte notamment de la surveillance, la préparation et la prévention de la violence politique. Ils devraient utiliser les nouvelles sciences des rapports humains justification pour considérer des rapports internationaux. La nécessité de rétablir les Nations Unies reformées au centre de la prise de décision internationales et d'augmenter la dépense globale pour le rétablissement de la paix sont deux conclusions de cette étude.

RESUMEN

La Globalización, el Conflicto y la Salud Mental

El conflicto violento para lograr fines políticos, incluso la guerra y la guerra civil, es la causa más grande de la mala salud mental. Aunque existen enfoques y maneras diferentes para entender esta relación, hay algún consenso sobre las reacciones psicológicas, sociales, y las reacciones entre diferentes sectores, frente a las situaciones de posguerra. La globalización ha cambiado las relaciones de los estados-nación, las corporaciones y las organizaciones internacionales, creando pautas diferentes de violencia política y maneras diferentes de organizar las reacciones. Las víctimas, las armas y la ayuda humanitaria están consideradas dentro de un marco de salud mental pública, describiendo las consecuencias de la guerra y otras formas de violencia política. Los niveles primarios y secundarios de intervención en la salud mental pública toman en consideración la preparación para la violencia política, su observación y su prevención. Toman las nuevas ciencias de las relaciones humanas como base para examinar las relaciones internacionales. La necesidad de restablecer las Naciones Unidas al centro de la toma de decisiones global y de aumentar el gasto global para medidas pacificadoras son dos conclusiones de este análisis.

BIOGRAPHICAL NOTE

JACK PIACHAUD is a psychiatrist working at the Medical Foundation for the Care of Victims of Torture and is a Board member of Medact. He is editor of the journal *Medicine Conflict and Survival*. He has worked in Zimbabwe and in the former Yugoslavia. Please address correspondence to: Jack Piachaud, 16 Arnos Road, London N11 1AP, UK. [email: jackpiachaud@medact.org]